

Speech-Language Pathologist Full License Application Checklist

All documentation must be original, on the forms currently in use by the Board, and submitted as a complete application packet. Incorrect and incomplete applications will delay the review and approval process. **The license must be obtained prior to employment.**

I. All Applicants Must Submit:

- _____ \$150.00 Fee (check or money order payable to the Board of SLP)
- _____ A recent 2x2 passport size color photo
- _____ Signed and Notarized Application
- _____ Completed Law and Regulation Examination

Application fee is non-refundable.

Note: To pass the open book examination, all applicants must score at least 75. You can download the examination from the Board's web site at <http://dhmh.maryland.gov/boardsahs/>. Use the Forms Link to download a copy of the SLP law examination. To complete the examination refer to the law and regulation reference number included with the question. Use the "Regulation" tab on the Board's web site to access the laws and regulations to answer the questions. A license will **not** be issued unless the Law and Regulation Examination is passed.

II. Documents To Be Submitted:

If Applicant Holds or Has Held ASHA-Issued Certificate of Clinical Competency:

- _____ Verification Letter of ASHA Certificate of Clinical Competency (contact ASHA)
- _____ Brief Resumé (if applicant has been practicing more than 5 years)
- _____ License affidavit from **all** states in which the applicant is currently licensed or has ever been licensed (use licensure affidavit form at the end of this application document or the process required by the state in which you are or were licensed).

If Applicant Does Not Have ASHA-Issued Certificate of Clinical Competency:

- _____ Official Master's Transcript
- _____ Praxis Exam Scores
- _____ Clinical Fellowship Year Plan (Form AS2)
- _____ Clinical Fellowship Year Verification (Form AS3)

State of Maryland & Department of Health and Mental Hygiene
**Board of Examiners for Audiologists, Hearing Aid Dispensers and
Speech-Language Pathologists**

4201 Patterson Avenue, Baltimore, Maryland 21215-2299

Phone 410-764-4725 Fax 410-358-0273

TTY/Maryland Relay Service 1-800-735-2258

Speech-Language Pathologist Full License Application

**Affix current
2x2 passport size photo**

☐ Applicant must check here if the applicant is a veteran or has received training in the military that is being applied to the education requirements for licensure.

1. Name _____
Last First Middle/Maiden

2. Home Address _____
Street Apt.

City State Zip Code

3. Home Phone #: _____ Alternate #: _____

E-Mail: _____

4. Date of Birth _____ 5. Social Security #: _____

6. Have you previously been licensed in the State of Maryland? _____ Yes _____ No

If yes, License #: _____ Date Expired: _____

7. Have you ever been convicted of a felony or a misdemeanor involving moral turpitude?
If **yes**, please explain on a separate sheet of paper and attach it to the application with copies of all relevant court documents.

For Office Use Only

Received _____ CH() MO () Number _____

8. Education

Graduate School: _____

Address: _____
Street City State Zip Code

Attended _____ to _____ Major _____ Date Degree Awarded _____

Undergraduate School: _____

Attended _____ to _____ Major _____ Date Degree Awarded _____

9. Do you hold, or have you ever held, the American Speech-Language-Hearing Association Certificate of Clinical Competence in Speech-Language Pathology? ____ Yes ____ No

If Yes, date originally granted _____

(A) Clinical Fellowship Year completed? ____ Yes ____ No

(B) Praxis Examination in Speech-Language Pathology Passed? ____ Yes ____ No

Note: If applicant does not have ASHA Certification, a certified official transcript showing credit hours in speech-language pathology must accompany this application.

If you answer no to #9(A) or (B,) enclose a professional resume. If you hold a CCC, proceed to #12. A Letter from ASHA must accompany the application.

10. Employment during Clinical Fellowship Year ó submit a Form AS2 for each place of employment during the period of limited licensure.

Date _____ Title of Position _____

Facility/Company Name _____

Address _____
Street City State Zip Code

Brief description of duties:

11. Supervision of Clinical Fellowship Year (CFY)

A. Submit Verification of Supervision for Limited Licensure Clinical Fellowship Year (From AS2) or copy of ASHA CFY

B. Submit Verification of Satisfactory Completion of Clinical Fellowship Year (Form AS3)

12. Are you now or have you ever been licensed in any other state? _____ If yes, please complete the first page of the Licensure Affidavit (AS4). Request each State licensure board to return the completed form to the Maryland Board office.

I am licensed in the following states: _____

I was licensed in the following states: _____

13. Has any disciplinary action ever been taken against your license in any jurisdiction?

_____Yes _____No

If yes, please explain on a separate sheet attached to this application.

14. This Affidavit must be completed by a Notary Public.

I hereby affirm that I have read Sections 2-101 to 2-502 of Title 2 of the Health Occupations Article of the Annotated Code of Maryland and fully understand that in receiving a license from the Board, I bind myself to be governed by the Board.

I understand that in submitting this application that the accompanying fee is for administrative purposes and is not refundable. The fee includes licensure fee.

State of _____ *City/County of* _____

The undersigned, being duly sworn, deposes and says that he/she is the person who executed this application, that the statements herein contained are true to the best of his/her knowledge, that he/she has not suppressed any information that might affect this application and that he/she has read and understands this affidavit.

Signature of Applicant

Signature of Notary

Subscribed and sworn to before this _____ day of _____

In accordance with Executive Order 01.01.1093-18, the Board is required to advise you as follows regarding the collection of personal information:

Personal information requested by the Board is necessary in determining your eligibility for licensure. Such personal information is also intended for use as an additional means of verifying the licensee's identity or to enable the Board to communicate, in a timely manner, with the licensee should the need arise. The licensee has a right to inspect his personal record and to amend or correct the personal data if necessary.

Your Social Security Number is needed on the application. It will be used for identification purposes and may be released to the Department of Public Safety and Correctional Services to check for any criminal convictions.

Race/Ethnic Identification

To further its commitment to equal access the Board of Examiners requests applicants to provide, voluntarily, the following information. This information will be used for statistical purposes only by authorized personnel.

Male _____ Female _____

Race/Ethnic Identification – Please Check All That Apply

Are you of Hispanic or Latino origin? ____ Yes ____ No (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Select one or more of the following racial categories:

1. ____ American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)
2. ____ Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
3. ____ Black or African American (A person having origins in any of the black racial groups of Africa.)
4. ____ Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
5. ____ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

SLP Full

State of Maryland 6 Department of Health and Mental Hygiene
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**Verification of Supervision for
Speech-Language Pathology Clinical Fellowship Year**

I. Applicant (Please type or print)

A. Name: _____
Last First Middle/Maiden

B. Address: _____
Street Apt.

City State Zip Code

Phone: _____ Alternate # _____ Email _____

C. Academic Status: _____
College Degree Date Awarded

D. Employment Setting:

Facility Name: _____

Street Address: _____

City State Zip Code

Phone: _____ Fax: _____

Beginning date of employment: _____
Month Day Year

Hours per week spent in Speech-Language Pathology? _____

Is applicant completing a CFY? _____ Yes _____ No

Form AS2

II. Supervisor of Limited Licensure year (please print or type)

A. Name: _____
Last First Middle/Maiden

B. Street Address: _____

City State Zip Code

C. Place of Employment: _____
Facility Name
Street
City State Zip Code
Phone: _____ Alternate # _____

III. Clinical and Supervisory Responsibility

Applicant Activity	Hours/Week Spent by Applicant	Hours/Month Spent by Supervisor	
		On-Site Observation (at least 4 hour per month)	Other Monitoring Activities (optional)
1. Assessment, diagnosis and/or evaluations			
2. Screening			
3. Habilitation/ rehabilitation			
4. Staff Meetings			
5. Supervisory Conferences			
6. In-Service Training			
7. Record Keeping			
8. Other (Must Specify)			
Total			

Signature of Applicant _____ Date _____

Signature of Supervisor _____ Date _____

Supervisor:

() Holds ASHA CCC-SLP, ASHA Certificate # _____

() Holds MD License in Speech-Language Pathology, License # _____

() Holds License in Speech-Language Pathology in State of _____

Form AS2

State of Maryland 6 Department of Health and Mental Hygiene
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**Verification of Satisfactory Completion of
Speech-Language Pathologist Clinical Fellowship Year**

I hereby declare that _____
Name of Applicant

of _____
Street City State Zip Code

an applicant for Maryland licensure in speech-language pathology, was employed as a
professional in that field from _____ to _____ for _____ hours per week.

The place of employment was _____
Facility Name

_____ Address City State Zip Code

I further declare that the applicant was supervised by _____
Name of Supervisor

At that time the CFY supervisor held (must be at least one of the following):

() Maryland License in Speech-Language Pathology License # _____

() ASHA Certification in Speech-Language Pathology Certificate # _____

() A License in Speech-Language Pathology from the State of _____
whose licensure requirements were equivalent to ASHA certification.

**I verify that during the employment period, the applicant reached a satisfactory level of
competence in the area in which licensure is sought.**

Signature of Supervisor

Typed or Printed Name

Title

Date

Current Phone Number

Form AS3

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Licensure Board Affidavit

This portion of the form is to be completed by the speech-language pathologist. Would you please verify the license in your jurisdiction for:

First Name _____ Middle Name _____ Last Name _____

Date of Birth _____ Social Security Number _____

Graduate of _____ Date _____

This portion of the affidavit to be completed by the Licensure Board.

License No. _____ Date Issued _____

With State Examination _____ Without Examination _____

Is license in good standing? _____ Expiration Date _____

Has the license ever been suspended or revoked? _____ If yes, please explain why:
Attach a separate sheet

Has the license been reinstated? _____

Has any disciplinary action been taken against the licensee? _____ If yes, please explain:

Is there any derogatory information on file concerning this licensee? _____ If yes, please explain:

Signature _____ Date _____

Title _____

Affix Board
Seal Here

State Board Name _____

State of _____